CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

CHAPTER II
TABLE OF CONTENTS

CHAPTER II
PROVIDER PARTICIPATION REQUIREMENTS

PARTICIPATING PROVIDER

A participating provider is a nursing facility that is certified by the Center for Quality Health Care Services and Consumer Protection, Virginia Department of Health, and that has a current, signed participation agreement with the Department of Medical Assistance Services (DMAS).

PROVIDER ENROLLMENT

A nursing facility must be enrolled in the Medicaid Program prior to billing for any services provided to Medicaid recipients. Billing forms will not be issued to providers who do not sign a participation agreement with DMAS. (See "Exhibits" at the end of this chapter for a copy of the Nursing Home Participation Agreement.)

The authorized agent of the nursing home should complete and sign (only original signatures are accepted) two nursing home participation agreements and return them to FIRST HEALTH Services Provider Enrollment and Certification.

Upon completion of the enrollment process, a seven-digit provider number will be assigned to each provider. This number must be used on all claims and correspondence submitted to Medicaid.

Instructions for billing and specific details concerning the Medicaid Program are contained in this manual. Read all sections of this manual before signing the agreement. The provider must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

REQUEST FOR PARTICIPATION

To become a Medicaid-certified provider of services, the nursing facility must request a participation agreement in writing from:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

Note: Certification by the Virginia Department of Health does not constitute automatic enrollment as a Medicaid provider.

PARTICIPATION REQUIREMENTS

Providers approved for participation in Medicaid must perform the following activities as

well as any other specified by DMAS:

- Immediately notify DMAS, in writing, whenever there is a change in any of the information that the provider previously submitted;
- Ensure freedom of choice to recipients in seeking medical care from any institution, pharmacy, or practitioner which participates in the Medicaid Program at the time the service is performed and which is qualified to perform the required service(s);
- Ensure the recipient's freedom to reject medical care and treatment;
- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the ground of race, color, or national origin;
- Provide services, goods, and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities;
- Not require, as a precondition for admission or continued stay, any period of private pay or a deposit from the resident or any other party;
- Accept Medicaid payment from the first day of eligibility, if Medicaid eligibility was pending at the time of admission. The nursing facility must accept payment back to the date of eligibility if the resident was in a certified bed, whether or not the facility knew that Medicaid application had been made;
- Provide services and supplies to recipients of the same quality and in the same mode of delivery that is provided to the general public;
- Charge DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public;
- Accept as payment in full the amount established by DMAS to be reasonable cost or maximum allowable cost. 42 CFR § 447.15, provides that "A State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual."

A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the state. A provider may not seek to collect from a Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established Medicaid allowance for the service rendered. For example, if a third party payer reimburses $5.00 out of an $8.00 charge, and Medicaid's allowance is $5.00, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the $3.00 difference from Medicaid, the recipient, a spouse, or a responsible relative. The provider may not bill DMAS or the recipient for broken or missed appointments;

- Accept assignment of Medicare benefits for eligible Medicaid recipients;
- Use program-designated billing forms for submission of charges;
- Maintain and retain the business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided;

  In general, such records must be retained for a period of not less than five years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved (refer to the section, “Documentation of Records”).

- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities;
- Disclose, as requested by the Program, all financial, beneficial ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of medical assistance; and
- Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding recipients. A provider shall disclose information in his or her possession only when the information is to be used in conjunction with a claim for health benefits or when the data is necessary for the functioning of the state agency.

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance.

Each Medicaid provider, as a condition of participation, is responsible for making provision for such disabled individuals in the program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. By signing the check, the provider indicates compliance with the Rehabilitation Act of 1973, as amended (29 USC § 794). In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) any evidence regarding compliance with these requirements.

REQUIREMENTS OF THE CIVIL RIGHTS ACT OF 1964

All providers of care and suppliers of services under contract with DMAS must comply with the requirements of Title VI of the Civil Rights Act of 1964, which requires that services be provided to Medicaid recipients without regard to race, color, or national origin.

NURSING FACILITY PARTICIPATION CONDITIONS

Responsible Party Requirements
[Effective Date: July 1, 1989]

Any nursing facility certified by Medicaid or Medicare shall not require a third party guarantee of payment to the facility as a condition of admission or of expedited admission to, or continued stay in, the facility. This does not prevent a facility from requiring an individual with legal access to a resident's income or resources available to pay for care in the facility to sign a contract without incurring personal financial liability except for breach of the duty to provide payment from the resident's income or resources for such care. The resident's income or resources shall include any amount deemed to be income or resources of the resident for purposes of Medicaid eligibility and any resources transferred by the resident to a third party if the transfer disqualifies the resident from Medicaid coverage for nursing facility services.

A nursing facility may require financial guarantees from a third party as a condition of admission or continued stay of a Medicaid recipient **only** if:

- The agreement is limited to non-covered services, and
- The agreement does not apply to covered services or prior time periods when the recipient is determined to be retroactively Medicaid-eligible.

Preconditions for Admission or Continued Stay in Medical Facilities

The right of Medicaid recipients to receive medical facility services is based upon medical necessity and a determination of eligibility by the local departments of social services in Virginia. Additional requirements, such as prior status as a private-paying resident, a preadmission deposit, gifts, donations, or other considerations may not be established by a participating provider as a precondition for admission or as a requirement for continued stay in a facility.

Federal regulations (42 CFR § 447.15) provide that participation will be limited to providers of service who accept as payment in full the amounts paid in accordance with the

fee structure. Section 4 of Public Law *95-142* (The Medicare-Medicaid Antifraud and Abuse Amendments of 1977, subsection (d) of 42 USC § 1320a-7b), quoted below, provides that certain actions by facilities constitute a criminal act:

> Whoever knowingly and willfully (1) charges, for any service provided to a patient under a State plan approved under subchapter XIX of this chapter, money or other consideration at a rate in excess of the rates established by the State (or, in the case of services provided to an individual enrolled with a medicaid managed care organization under subchapter XIX of this chapter under a contract under section 1396b(m) of this title or under a contractual, referral, or other arrangement under such contract, at a rate in excess of the rate permitted under such contract), or (2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under subchapter XIX of this chapter, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--(A) as a precondition of admitting a patient to a hospital, nursing facility, or intermediate care facility for the mentally retarded, or (B) as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

Medicaid policies regarding preconditions for admission or continued stay address three specific situations:

- **The patient is Medicaid-eligible at the time of admission -** If a patient is admitted to a Medicaid-enrolled facility, there can be no precondition for admission requiring any period of private pay or a deposit from the resident or any other party.

- **Medicaid eligibility is pending at the time of admission** – Medicaid long-term care providers cannot collect more than the Medicaid rate from a Medicaid recipient. When Medicaid eligibility is determined, it is most often made retroactive to a time prior to the date that the eligibility decision is made. Federal statutory and regulatory requirements mandate that the nursing facility accept Medicaid payment as payment in full when a person's Medicaid eligibility begins. Thus, nursing facilities are required to refund any excess payment received from a resident or family member for the period of time that the Medicaid eligibility was pending and the resident is determined eligible for Medicaid.

- **A private-pay resident applies for Medicaid and becomes eligible after admission -** An enrolled provider may not require discharge of the resident or continue to require a period of private pay subsequent to the initial eligibility date for residents in Medicaid-certified units. The Virginia Medicaid Program must be billed for all covered services delivered by a provider beginning with

the date of eligibility in such cases (42 CFR §§ 442.311 and 405.121 and § 32.1-138 of the Code of Virginia, 1950 as amended).

NOTE: Nothing in this section is to be construed to alter DMAS policy concerning nursing facility preadmission screening (see Chapter VI of this manual).

Preadmission Screening of Mentally Ill and Mentally Retarded Individuals

As a condition of Medicaid participation, all individuals who apply for nursing facility admission must be screened for conditions of mental illness and mental retardation and to determine if Medicaid-eligible applicants meet the criteria for nursing facility placement. It is the responsibility of the nursing facility to ensure that the applicable requirements are met. Refer to Chapter VI for specific policies and procedures regarding these requirements.

Certain Contract Provisions Prohibited

Section 32.1-138.2 of the Code of Virginia requires:

> No contract or agreement for nursing home care shall contain any provisions which restrict or limit the ability of a resident to apply for and receive Medicaid or which require a specified period of residency prior to applying for Medicaid. The resident may be required to notify the facility when an application for Medicaid has been made. No contract or agreement may require a deposit or other prepayment from Medicaid recipients. No contract or agreement shall contain provisions authorizing the facility to refuse to accept retroactive Medicaid benefits.

Nursing Home

For the purpose of Medicaid, a nursing home is a licensed institution, public or private, or a part thereof, which provides on a regular basis health-related care and services to individuals who do not require the degree of care and treatment which a hospital is designed to provide, but who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities.

To become a DMAS provider, a nursing home must:

- Be licensed and certified by the Virginia Department of Health as meeting standards required by federal regulation to provide nursing facility services or be identified as a distinct part of another medical institution which is either operated by the state or licensed by the appropriate state authority (e.g., a state institution for the mentally retarded);
- Enter into a participation agreement with DMAS;
- Comply with the participation requirements of DMAS; and

- Submit acceptable financial data to establish a Medicaid reimbursement rate with DMAS.

Nursing facility care is defined as the provision primarily of resident services such as: help in walking, transferring, bathing, dressing, feeding, preparation of diet, supervision of medications which cannot be safely self-administered, and other types of personal assistance which are usually provided by trained nurses' aides and licensed nurses under the supervision of a professional registered nurse. Nursing facility criteria are defined in Appendix B.

Specialized Care/Long Stay Hospital (LSH)

Specialized care and long stay care hospitals target residents who require a higher intensity of nursing care than that which is normally provided in a nursing facility and who do not require the degree of care and treatment that a hospital is designed to provide. Care must be provided by a nursing facility or long-stay hospital. The resident must have long-term health conditions requiring close medical supervision, 24 hours of licensed nursing care, and specialized services or equipment. Admission requirements are outlined in Chapter VI.

It is intended that the per diem received by the facility for providing specialized care services be all-inclusive for the resident's care with the exception of certain allowable items (e.g., medications) that would be billed by the pharmacy. For example, nursing facilities may not bill Medicare Part B for the tube-feeding portion of the resident's care for enterally fed residents who are in specialized care beds. In addition, the facility may not bill the coinsurance portion of the tube-feeding claim to Medicaid, as this would constitute a double billing to the Medicaid Program.

Note: Nursing facilities and long stay care hospitals must have a separate contract with DMAS to receive reimbursement for specialized care or long stay hospital level of care.

Facilities for the Mentally Retarded

For Medicaid purposes, a facility for the mentally retarded is a licensed facility, public or private, which provides health and (re)habilitative services for persons who are mentally retarded or have "related conditions."

To participate in Medicaid, a facility for the mentally retarded must be certified by the Virginia Department of Health as meeting standards required by federal regulations to provide intermediate care for the mentally retarded and must comply with the participation requirements of DMAS. The facility may be identified as a distinct part of another medical institution that is operated by the state or licensed by the appropriate state authority.

In addition to meeting the certification and participation requirements, the facility must provide "active treatment" as defined in the 42 CFR §§ 435.1009 and 483.440. "Active treatment" includes each of the following:

- Each resident must receive a continuous active treatment program, which includes the aggressive, consistent implementation of a program of specialized

and generic training, treatment, health services, and related services directed toward: 1) the acquisition of behaviors necessary for the resident to function with as much self-determination and independence as possible, and 2) the prevention or deceleration of regression or loss of current optimal functional status. (Active treatment does not include services to maintain generally independent residents who are able to function with little supervision or in the absence of a continuous active treatment program.);

- Each resident must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines, or service areas that are relevant to identifying the resident's needs and designing programs to meet those needs; and

- Appropriate facility staff must participate in interdisciplinary team meetings. Participation by the resident and his or her parent or guardian is required unless unobtainable or inappropriate.

Assessments required are:

- Admission decisions must be based on a preliminary evaluation of the resident conducted or updated by the facility or outside sources. This evaluation must include background information as well as currently valid assessments of functional developmental, behavioral, social, health, and nutritional status;

- Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. The comprehensive functional assessment must take into consideration the resident's age and implications for active treatment at each stage, as applicable;

- Within 30 days after admission, the interdisciplinary team must prepare for each resident an individual program plan stating the specific measurable objectives in behavioral terms which are necessary to meet the resident's needs and the planned sequence for dealing with those objectives;

- As soon as the interdisciplinary team has formulated a resident's individual program plan, the resident must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary;

- At least annually, the comprehensive functional assessment of each resident must be reviewed by the interdisciplinary team for relevancy and updated as needed, and the individual program plan must be revised, as appropriate; and

- At the time of discharge, the facility must develop a final summary of the resident's development, behavioral, social, health, and nutritional status and,

with the consent of the resident, parents (if the resident is a minor), or legal guardian, provide a copy to authorized persons and agencies and provide a post-discharge plan of care that will assist the resident with adjusting to the new living arrangement.

Services for mentally retarded persons are defined as a combination of habilitative, rehabilitative, and health services directed toward increasing the functional capacity of the retarded person. The overall objective of programming shall be the attainment of the optimal physical, intellectual, social, and task-learning level that the person can presently or potentially achieve. Criteria for facilities for the mentally retarded are included in Appendix B.

Institutions for Mental Diseases (IMD)

An institution for mental diseases is a public or private facility that is certified by the Department of Health. Any facility may be considered an institution for mental diseases when it is established or maintained primarily for the care and treatment of individuals with mental diseases. In Virginia, medical assistance is available only for those recipients in institutions for mental diseases when the recipient is over the age of 65. The following guidelines are used in determining whether or not a facility is an institution for mental diseases:

- The facility is licensed as a psychiatric facility for the care and treatment of individuals with mental diseases;
- The facility advertises or holds itself out as a facility for the care and treatment of individuals with mental diseases;
- The facility is accredited as a psychiatric facility by the Joint Commission for Accreditation of Hospitals;
- The facility specializes in providing psychiatric care and treatment. This may be ascertained through review of residents' records and may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric training;
- The facility is under the jurisdiction of the Commonwealth's mental health authority (the Department of Mental Health and Mental Retardation and Substance Abuse Services (DMHMRSAS));
- More than 50 percent of the residents have a diagnosis of a mental disease, which requires inpatient treatment and is documented in their medical records;
- A large proportion of the residents in the facility has been transferred from a state mental institution for continuing treatment of their mental disorders;
- Independent professional review teams report a preponderance of mental illness in the diagnoses of the residents in the facility;

- The average age in the facility is significantly lower than that of a typical nursing facility; and

- Part or all of the facility consists of locked wards.

Out-of-State Nursing Facilities

Generally, non-enrolled, out-of-state nursing facilities are subject to the same policies and program limitations as participating nursing facilities, except that non-enrolled out-of-state, non-participating nursing facilities will be reimbursed based upon the average per diem reimbursement to enrolled nursing facilities.

If the specific nursing facility's services required by the resident are available in a Virginia nursing facility within a reasonable distance of the recipient's home, the recipient should not be referred to an out-of-state nursing facility.

UTILIZATION OF INSURANCE BENEFITS

Health, hospital, workers' compensation, or accident insurance benefits shall be used to the fullest in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

- **Title XVIII (Medicare)** - Medicaid will pay the amount of any deductible or coinsurance up to the Medicaid limits for covered health care benefits under Title XVIII of the Social Security Act for all eligible persons covered by Medicare and Medicaid.

- **Workers' Compensation** - No Medicaid payments shall be made for a patient covered by workers' compensation.

- **Other Health Insurance** - When a recipient has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), Medicaid requires that these benefits be used first. Supplementation shall be made by Medicaid when necessary, but the combined total payment from all insurance shall not exceed the amount payable under DMAS had there been no other insurance.

- **Liability Insurance for Accidental Injuries** - The Virginia Medicaid Program will seek repayment from any settlements or judgments in favor of Medicaid recipients who receive medical care as the result of the negligence of another. If a recipient is treated as the result of an accident and the Virginia Medical Assistance Program is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to establish any lien that may exist under § 8.01-66.9 of the Code of Virginia. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing Medicaid.

In the case of an accident in which there is a possibility of third-party liability or if the recipient reports a third-party responsibility (other than those cited on his or her Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the physician is requested to forward the DMAS-1000 to:

Third-Party Liability Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

See "Exhibits" at the end of this chapter for a sample of this form.

DOCUMENTATION OF RECORDS

The Nursing Facility Provider Agreement requires that the medical records fully disclose the extent of services provided to Medicaid recipients. The following elements are a clarification of Medicaid policy regarding documentation for medical records:

- The record must identify the resident on each page;
- Entries must be signed (with first initial, last name, followed by professional title) and dated (month, day, year) by the author. Care rendered by personnel under the supervision of the provider, which is in accordance with Medicaid policy, must be countersigned by the responsible licensed participating provider;
- The record must contain a preliminary working diagnosis and the elements of a history and physical examination upon which the diagnosis is based;
- All services provided, as well as the treatment plan, must be entered in the record. Any drugs prescribed and administered as part of a physician's treatment plan, including the quantities, route of administration, and the dosage, must be entered in the record; and
- The record must indicate the resident's progress, any change in diagnosis or treatment, and the response to treatment. For additional record documentation requirements, see Chapter VI.

TERMINATION OF PROVIDER PARTICIPATION

The Participation Agreement will be time-limited with periodic renewals required. DMAS will request a renewal of the Participation Agreement prior to the expiration of the agreement. A participating provider may terminate his or her participation in Medicaid by giving written notification of voluntary termination to the Director of the Department of Medical Assistance Services 30 days prior to the effective date.

DMAS may terminate a provider from participation upon written notification to the provider 30 days prior to the effective date. Such action precludes further payment by DMAS for services provided to recipients subsequent to the date specified in the termination notice. Section 32.1-325(c) of the Code of Virginia mandates that "Any such (Medicaid) agreement or contract shall terminate upon conviction of the provider of a felony."

RECONSIDERATION OF ADVERSE ACTIONS

Non-State-Operated Providers

The following procedures are available to providers when DMAS takes adverse action, including termination or suspension of the provider agreement and denial of payment for services rendered based on compliance review decisions.

The reconsideration process consists of three phases: a written response and reconsideration to the preliminary findings, an informal conference, and a formal evidentiary hearing. The provider has 30 days to submit information for written reconsideration and has 30 days' notice to request an informal conference or formal evidentiary hearing.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Virginia Administrative Process Act (APA) (§§ 9-6.14:1 through 9-6.14:25 of the Code of Virginia) and *the State Plan for Medical Assistance* provided for in § 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the APA.

Any legal representative of a provider must be duly licensed to practice law in the Commonwealth of Virginia.

State-Operated Provider

The following procedures are available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement and denial of payment for services rendered based on compliance review decisions. State-operated provider means a provider of Medicaid services which is enrolled in the Medicaid Program and operated by the Commonwealth of Virginia. A state-operated provider has the right to request a reconsideration for any issue which would be otherwise administratively appealable under the *State Plan for Medical Assistance* by a non-state-operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process consists of three phases: an informal review by the Division Director, DMAS Director review, and Secretarial review. First, the state-operated provider will submit to the appropriate DMAS Division written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives its Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought; the amount of the adjustment sought; and the reasons for seeking

the adjustment. The Division Director will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution. Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable law and regulations. The Division Director will consider any recommendation of his or her designee and render a decision.

A state-operated provider may, within 30 days after receiving the informal review decision of the Division Director, request that the DMAS Director or his designee review the decision of the Division Director. The DMAS Director has the authority to take whatever measures he deems appropriate to resolve the dispute.

If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 days after receipt of the decision of the DMAS Director, the provider may request that the DMAS Director refer the matter to the Secretary of Health and Human Resources or any other Cabinet Secretary as appropriate. Any determination by such Secretary or Secretaries will be final.

MEDICAID PROGRAM INFORMATION

A provider may not wish to receive a provider manual and Medicaid Memos because he or she has access to the publications as part of a group practice. To suppress the receipt of this information, DMAS requires a statement from the provider. To suppress the receipt of the provider manual and Medicaid memoranda, send a written request to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

The provider named in the request will no longer receive publications from Virginia Medicaid. To resume the mailings, send a written request to the same address.

EXHIBITS

TABLE OF CONTENTS

Medicaid Provider Number_____

Cancellation Clause
Effective _____
This Agreement Terminates
on _____

Commonwealth of Virginia
Department of Medical Assistance Services
Medical Assistance Program
Nursing Home Participation Agreement

This is to certify that SAMPLE _____
(Name of Nursing Home)

of _____ . _____ . _____
(Street Address) (City & State) (Zip Code)

on this _____ day of _____, 19____, agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

Provider payments and information should be sent to _____
(Name)

of _____ . _____ . _____ _____ if
(Street Address) (City) (State) (Zip Code)
different from above.

1. The provider is currently licensed and certified under applicable laws and is not as a matter of state or federal law disqualified from participating in this Program.
2. Services will be provided without regard to race, color, religion, or national origin. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of 1973, 29 USC.706) VMAP. The patient must be an eligible recipient of medical assistance in Virginia and affected by disease or disability requiring nursing care certified by the attending physician.
3. The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the state plan. Access to records and facilities by authorized VMAP representatives, the Attorney General of Virginia or his authorized representatives, and federal personnel will be permitted upon reasonable request.
4. The provider agrees to care for patients at the current rate established by VMAP, and shall submit requests for payments in accordance with VMAP policies.
5. The provider agrees to pursue all other health care resources of payment *prior* to submitting a claim to VMAP.
6. The provider agrees that when a patient is discharged to a hospital, the provider shall assure that the patient be given an opportunity to be re-admitted to the facility at the time of the next available vacancy.
7. Payment made under VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited and may subject the provider to federal or state prosecution.
8. Should this agreement be terminated for any reason, it shall be the responsibility of VMAP to identify alternate sources of care.
9. In addition to its other obligations hereunder, the provider agrees that it is responsible to care for its patients who are eligible for medical assistance, to protect and maintain their health and safety, and to assist VMAP upon request in locating alternative sources of care for such patients. These obligations shall survive any cancellation, termination or expiration of this agreement until alternative sources of care are found for all such patients.
10. Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.
11. The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended.
12. This agreement may be terminated at will on thirty days' written notice by either party and may be terminated at will by VMAP upon decertification and/or loss of license.
13. All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.
14. This agreement shall commence on _____ and terminate on _____
(To Be Completed By Medicaid)

Please be sure to complete both sides of this form.

DO NOT USE:

Department of Medical Assistance Services

SAMPLE

by: _____ _____
Signature Date

Director, Division of Operations and Provider Services
Title

Provider of Services

by: _____ _____
Signature of Provider Date

_____
Title

___ City or ___ County of _____

_____
IRS Identification Number/ Social Security Number

(_____) _____
Area Code Telephone No.

Mail two completed copies to: Provider Enrollment and Certification Unit
Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, Virginia 23219

DMAS-129 R-4 88

Medicaid Provider Number _____

Commonwealth of Virginia
Department of Medical Assistance Services
Medical Assistance Program
Special Care Participation Agreement

This is to certify that _____
(Name of Facility)

of _____, _____, _____
(Street Address) (City & State) (Zip Code)

on this _____ day of _____, 19 _____, agrees to participate in the Virginia Medical Assistance Program (VMAP). The Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

Provider payments and information should be sent to _____
(Name)

of _____, _____, _____ if
(Street Address) (City & State) (Zip Code)
different from above.

1. The provider is currently licensed and certified under applicable laws and is not as a matter of state or federal law disqualified from participating in this Program, and has been fully certified by the Department of Medical Assistance Services to provide the service(s) checked below and assures that the service(s) are provided in accordance with laws, regulations, and policies governing the VMAP.

   ____ Complex Care
   ____ AIDS Care
   ____ Ventilator Dependent Care
   ____ Rehabilitation Care

2. Services will be provided without regard to race, color, religion, or national origin. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of 1973, 29 USC.706) VMAP. The patient must be an eligible recipient of medical assistance in Virginia and affected by disease or disability requiring nursing care certified by the attending physician.
3. The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized VMAP representatives and the Attorney General of Virginia or his authorized representatives, and federal personnel will be permitted upon reasonable request.
4. The provider agrees to care for patients at the current rate established by VMAP, and shall submit requests for payments in accordance with VMAP policies.
5. The provider agrees to pursue all other health care resources of payment prior to submitting a claim to VMAP.
6. The provider agrees that when a patient is discharged to a hospital, the provider shall assure that the patient be given an opportunity to be re-admitted to the facility at the time of the next available vacancy.
7. Payment made under VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited and may subject the provider to federal or state prosecution.
8. Should this agreement be terminated for any reason, it shall be the responsibility of VMAP to identify alternate sources of care.
9. In addition to its other obligations hereunder, the provider agrees that it is responsible to care for its patients who are eligible for medical assistance, to protect and maintain their health and safety, and to assist VMAP upon request in locating alternative sources of care are found for all such patients.
10. Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.
11. The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended.
12. This agreement may be terminated at will on thirty days' written notice by either party and may be terminated at will by VMAP upon decertification and/or loss of license.
13. All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.
14. This agreement shall commence on _____ and terminate on _____.
    (To Be Completed By Medicaid)

DO NOT USE
For Department of Medical Assistance Services use only

by: _____ _____
Signature Date

Director, Division of Client Services
Title

For Provider of Services by:

_____
Signature of Provider Date

__City or __ County of _____

_____
IRS Identification Number/Social Security #

(_____) _____
Area Code Telephone No.

Mail two completed copies to: Provider Enrollment/Certification Unit
Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, Virginia 23219

VIRGINIA

Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, Virginia
23219

THIRD PARTY LIABILITY INFORMATION REPORT

(FOR MEDICAID PROVIDERS' USE)

This form MUST be submitted to the Department of Medical Assistance Services within 30 days after a service is rendered to a Virginia Medicaid recipient for the treatment of accident related injuries. Federal Regulations (42CFR - 433.138) require the Department of Medical Assistance Services to exert positive efforts toward locating liable third parties and to diligently seek refunds of applicable liability payments. Please complete this form to the best of your knowledge to assist us in this effort. Statutory authority is provided for full recovery of funds from liable third parties in Section 8.01-66.9 of the Code of Virginia.

PLEASE TYPE OR PRINT

NAME OF RECIPIENT: _____
(LAST) (FIRST) (MI)

RECIPIENT'S ELIGIBILITY NO. _____ DATE OF INJURY _____

TYPE OF ACCIDENT _____ DATE YOUR SERVICE BEGAN _____
(WORK, AUTO, HOME, GUNSHOT, ETC.)

NAME OF ATTORNEY _____

ADDRESS _____

(IF RECIPIENT HAS AN ATTORNEY, THE FOLLOWING INFORMATION IS NOT NEEDED.)

NAME OF INSURANCE COMPANY _____

ADDRESS _____

NAME OF INSURED PERSON _____

POLICY NO. _____ CLAIM NO. _____

COMMENTS _____

_____

_____

DIAGNOSIS _____ NAME OF PROVIDER _____

IS TREATMENT COMPLETED _____ YES _____ NO

DATE _____ BY _____

Providers will not be involved in litigation or collection attempts by the Department of Medical Assistance Services nor will reimbursement to the provider be withheld as a result of submitting this form.

PLEASE MAIL TO:

THIRD PARTY LIABILITY/CASUALTY
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 E. BROAD STREET, SUITE 1300
RICHMOND, VIRGINIA 23219

DMAS - 1000 R9/87